Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 2, 2023

Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

RE: CCN: 245269
Cycle Start Date: January 19, 2023

Dear Administrator:

On February 23, 2023, the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 2, 2023

Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

Re: Reinspection Results
Event ID: 0TWF12

Dear Administrator:

On February 23, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 19, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 26, 2023

Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

RE: CCN: 245269
Cycle Start Date: January 19, 2023

Dear Administrator:

On January 19, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by April 19, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 19, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

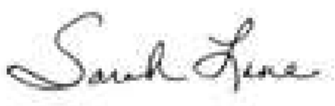
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
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Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245269	A. BUILDING _____ B. WING _____	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SHEPHERD LUTHERAN HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/17/23, to 1/19/23, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint were found to be UNSUBSTANTIATED, H52697299C (MN00089882), H54347421C The following complaint was found to be SUBSTANTIATED: H52697657C (MN00090106), with a deficiency cited at 689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		2/13/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/02/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were following fall risk interventions implemented for 1 of 3 (R1) residents reviewed for falls. Findings include: R1's quarterly Minimum Data Set (MDS) dated 11/15/22, identified R1 had severely impaired cognition and had diagnosis which included non-traumatic brain dysfunction, non-Alzheimer dementia and repeated falls. Identified R1 required limited assistance from staff with transfers and extensive staff assistance for toileting. R1's fall assessment dated 11/15/22, identified R1 was at high risk for falls due to impaired cognition and previous falls. R1's fall assessment indicated R1 overestimated or forgot her limitations. R1's care plan revised 6/8/22, identified R1 was at risk for falls and required assistance from staff with mobility and transfers. R1's care plan directed staff to ensure her call light was within reach and R1 was wearing appropriate footwear when ambulating or mobilizing in a wheelchair. Directed staff to ensure her four wheeled walker (4 WW) was close by R1 to promote success with self - transfers. Review of R1's Kardex dated 2/25/22, revealed the following: R1 required assistance with transfers and toileting. The Kardex directed staff to ensure call light was within reach, ensure R1	F 689	The facility has a process in place to ensure the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance to prevent accidents. In regard to R1, the facility does recognize R1's four wheeled walker was not within reach as it was indicated to be on R1's plan of care during the times noted by the surveyor. The care plan and Kardex for R1 have been reviewed and revised as necessary. Care plans for all other residents who have the potential to be affected by the deficient practice will also be reviewed and revised as necessary. Facility nursing staff will be reeducated with enhanced focus on their responsibility to know appropriate falls interventions for each resident and to follow the resident plan of care to reduce the risk of falls and injury to residents. Education on the importance of documenting immediate interventions to reduce further falls will also be completed. All applicable policies have been reviewed and revised as needed. An audit of falls documentation going back one month will be completed for all residents to ensure immediate interventions were put in place when a resident fell. To assure sustainability, going forward, audits will be conducted to assure incident reports include immediate interventions to	

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F 689	Continued From page 2 was wearing appropriate footwear when ambulating or mobilizing in wheelchair and to keep her 4WW close by to promote success with self -transfers. Review of R1's adverse event reports from 11/23/22, to 1/15/23, revealed the following: -11/23/22, R1 had an unwitnessed fall at 11:00 a.m. The event report identified R1 was found lying on the floor on her left side with her feet pointing to her bed and her head resting on the floor next to her recliner. The report revealed R1 was attempting to get up from bed and transfer to her chair. The report lacked immediate interventions to prevent future falls. -11/24/22, R1 had an unwitnessed fall at 10:50 a.m. The event report identified R1 was found lying on the floor on her back with her head pointed towards her bed, feet pointing towards the bathroom and her side table was tipped over on it's side. The report identified prior to the fall, R1 had been observed sleeping in her recliner with the side table in front of her. The report lacked immediate interventions to prevent future falls. -12/18/22, R1 had an unwitnessed fall at 2:00 a.m. The event report identified R1 was found lying on the floor parallel to her bed with her head at the foot of the bed. The report indicated R1 stated she attempted to get up from her bed and take herself to the bathroom however lost her balance and fell. The report revealed staff assisted R1 to the bathroom and re-educated her to use the call light for assistance. -12/21/22, R1 had an unwitnessed fall at 10:30	F 689	reduce further falls. These audits will be conducted daily x 5 days, weekly x 2 weeks Monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility QA meetings. Audits will also be conducted to ensure that falls interventions are being followed to reduce the risk of falls and injury for all residents who may be affected by the deficient practice. These audits will be conducted daily x 5 days, weekly x 2 weeks Monthly x 2 months and periodically thereafter. The results from these audits will be reviewed at the facility QA meetings.	

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F 689	Continued From page 3 a.m. The event identified R1 was found lying on the floor in her bathroom doorway. The report revealed R1 was attempting to use the bathroom. -incident note dated 12/23/23, indicated current falls seemed to center around toileting however, after most recent assessment of bowel and bladder no toileting pattern had been identified. Incident note identified interventions which included hourly rounds to anticipate needs, reminder signs, call light within reach, appropriate footwear and 4WW at R1's bedside to promote success with anticipated self transfers. -12/25/22, R1 had an unwitnessed fall at 2:49 p.m. The event report revealed R1 was found lying on the floor near the bathroom. The report identified R1 stated she believed she hit the side of her head however could not remember for certain. The report revealed a neurological assessment was completed (neuro's) and was within normal limits. The report lacked immediate interventions to prevent future falls. -12/31/22, R1 had an unwitnessed fall at 1:49 p.m. The event report revealed R1 was found on the floor outside her bathroom. The report identified R1 was transferred to bed. The report lacked immediate interventions to prevent future falls. -incident note dated 1/10/22, indicated R1 was to be toileted at 2:00 a.m., 10:00 a.m., 2:00 p.m.,10:00 p.m. and before and after meals as a toileting trial. The incident note identified all other care planned items remained appropriate and were in place. -1/15/23, R1 had an unwitnessed fall at 5:00 a.m.	F 689		

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F 689	Continued From page 4	F 689		

The event report revealed R1 was found sitting on her bottom on the floor in her room near the foot of the bed. The report lacked immediate interventions to prevent future falls.

During an observation on 1/18/23, at 9:45 a.m. R1 was lying in bed, call light was within reach and her 4WW was noted to be pushed up against the wall approximately three feet from the bed out of R1's reach.

During an observation on 1/18/23, at 10:30 a.m. R1 was lying in bed, call light was within reach and 4WW continued to be pushed up against the wall approximately three feet from the bed out of R1's reach.

During an observation on 1/19/23, at 7:01 a.m. R1 was lying in bed, call light was within reach and 4WW was noted to be on the left side of the room approximately five feet away from the bed. At 7:20 a.m. nursing assistant (NA-A) entered R1's room to assist resident to get dressed. NA-A stated the FWW should have been next to R1's bed and she proceeded to place the walker next to the bed.

During an interview on 1/19/23, at 7:41 a.m. NA-A stated R1 required moderate assistance with her activities of daily living (ADL's). NA-A indicated R1 had several falls and one of R1's fall interventions was to keep the 4WW close to the bed. NA-A stated R1 had falls while using the bedside table with wheels as a walker when the 4WW was not accessible to her. NA-A confirmed the 4WW was not close to the bed and out of R1's reach when she arrived in R1's room earlier that morning.

During an interview on 1/19/23, at 7:50 a.m.

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F 689	Continued From page 5 licensed practical nurse (LPN-A) indicated R1 was at risk for falls and had several falls. LPN-A stated staff were expected to place R1's 4WW near her bed when R1 was in bed as she was impulsive and known to self transfer. LPN-A confirmed R1's 4WW was not placed next to the bed earlier that morning and was out of R1's reach. During an interview on 1/19/23, assistant director of nursing (ADON) verified R1 had several falls while self transferring. ADON confirmed one of the care planned interventions was for staff to keep R1's 4WW close to her while she was in bed or in her recliner. ADON stated it was her expectation staff would have followed care planned interventions. A facility policy titled "Falls Policy" revised 5/22, revealed a fall as any unintentional change in position coming to rest on the ground, floor or onto the next lower surface. The policy identified falls were discussed with interdisciplinary team (IDT) to form potential patterns and interventions.	F 689		

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F 689	Continued From page 6	F 689		

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 26, 2023

Administrator
Good Shepherd Lutheran Home
1115 4th Avenue North
Sauk Rapids, MN 56379

Re: State Nursing Home Licensing Orders
Event ID: 0TWF11

Dear Administrator:

The above facility was surveyed on January 17, 2023 through January 19, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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GOOD SHEPHERD LUTHERAN HOME	1115 4TH AVENUE NORTH SAUK RAPIDS, MN 56379

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/17/23, to 1/19/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 The following complaint was found to be UNSUBSTANTIATED: H52697299C (MN00089882). The following complaint was found to be SUBSTANTIATED: H52697657C (MN00090106), with a licensing order issued at 0830. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the	2 000		

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2 000	Continued From page 2 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were following fall risk interventions implemented for 1 of 3 (R1) residents reviewed for falls. Findings include:	2 830	Acknowledged.	2/13/23

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2 830	Continued From page 3 R1's quarterly Minimum Data Set (MDS) dated 11/15/22, identified R1 had severely impaired cognition and had diagnosis which included non-traumatic brain dysfunction, non-Alzheimer dementia and repeated falls. Identified R1 required limited assistance from staff with transfers and extensive staff assistance for toileting. R1's fall assessment dated 11/15/22, identified R1 was at high risk for falls due to impaired cognition and previous falls. R1's fall assessment indicated R1 overestimated or forgot her limitations. R1's care plan revised 6/8/22, identified R1 was at risk for falls and required assistance from staff with mobility and transfers. R1's care plan directed staff to ensure her call light was within reach and R1 was wearing appropriate footwear when ambulating or mobilizing in a wheelchair. Directed staff to ensure her four wheeled walker (4 WW) was close by R1 to promote success with self - transfers. Review of R1's Kardex dated 2/25/22, revealed the following: R1 required assistance with transfers and toileting. The Kardex directed staff to ensure call light was within reach, ensure R1 was wearing appropriate footwear when ambulating or mobilizing in wheelchair and to keep her 4WW close by to promote success with self -transfers. Review of R1's adverse event reports from 11/23/22, to 1/15/23, revealed the following: -11/23/22, R1 had an unwitnessed fall at 11:00 a.m. The event report identified R1 was found	2 830		

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2 830	Continued From page 4 lying on the floor on her left side with her feet pointing to her bed and her head resting on the floor next to her recliner. The report revealed R1 was attempting to get up from bed and transfer to her chair. The report lacked immediate interventions to prevent future falls. -11/24/22, R1 had an unwitnessed fall at 10:50 a.m. The event report identified R1 was found lying on the floor on her back with her head pointed towards her bed, feet pointing towards the bathroom and her side table was tipped over on it's side. The report identified prior to the fall, R1 had been observed sleeping in her recliner with the side table in front of her. The report lacked immediate interventions to prevent future falls. -12/18/22, R1 had an unwitnessed fall at 2:00 a.m. The event report identified R1 was found lying on the floor parallel to her bed with her head at the foot of the bed. The report indicated R1 stated she attempted to get up from her bed and take herself to the bathroom however lost her balance and fell. The report revealed staff assisted R1 to the bathroom and re-educated her to use the call light for assistance. -12/21/22, R1 had an unwitnessed fall at 10:30 a.m. The event identified R1 was found lying on the floor in her bathroom doorway. The report revealed R1 was attempting to use the bathroom. -incident note dated 12/23/23, indicated current falls seemed to center around toileting however, after most recent assessment of bowel and bladder no toileting pattern had been identified. Incident note identified interventions which included hourly rounds to anticipate needs, reminder signs, call light within reach, appropriate	2 830		

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2 830	Continued From page 5 footwear and 4WW at R1's bedside to promote success with anticipated self transfers. -12/25/22, R1 had an unwitnessed fall at 2:49 p.m. The event report revealed R1 was found lying on the floor near the bathroom. The report identified R1 stated she believed she hit the side of her head however could not remember for certain. The report revealed a neurological assessment was completed (neuro's) and was within normal limits. The report lacked immediate interventions to prevent future falls. -12/31/22, R1 had an unwitnessed fall at 1:49 p.m. The event report revealed R1 was found on the floor outside her bathroom. The report identified R1 was transferred to bed. The report lacked immediate interventions to prevent future falls. -incident note dated 1/10/22, indicated R1 was to be toileted at 2:00 a.m., 10:00 a.m., 2:00 p.m.,10:00 p.m. and before and after meals as a toileting trial. The incident note identified all other care planned items remained appropriate and were in place. -1/15/23, R1 had an unwitnessed fall at 5:00 a.m. The event report revealed R1 was found sitting on her bottom on the floor in her room near the foot of the bed. The report lacked immediate interventions to prevent future falls. During an observation on 1/18/23, at 9:45 a.m. R1 was lying in bed, call light was within reach and her 4WW was noted to be pushed up against the wall approximately three feet from the bed out of R1's reach. During an observation on 1/18/23, at 10:30 a.m.	2 830		

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2 830	Continued From page 6 R1 was lying in bed, call light was within reach and 4WW continued to be pushed up against the wall approximately three feet from the bed out of R1's reach. During an observation on 1/19/23, at 7:01 a.m. R1 was lying in bed, call light was within reach and 4WW was noted to be on the left side of the room approximately five feet away from the bed. At 7:20 a.m. nursing assistant (NA-A) entered R1's room to assist resident to get dressed. NA-A stated the FWW should have been next to R1's bed and she proceeded to place the walker next to the bed. During an interview on 1/19/23, at 7:41 a.m. NA-A stated R1 required moderate assistance with her activities of daily living (ADL's). NA-A indicated R1 had several falls and one of R1's fall interventions was to keep the 4WW close to the bed. NA-A stated R1 had falls while using the bedside table with wheels as a walker when the 4WW was not accessible to her. NA-A confirmed the 4WW was not close to the bed and out of R1's reach when she arrived in R1's room earlier that morning. During an interview on 1/19/23, at 7:50 a.m. licensed practical nurse (LPN-A) indicated R1 was at risk for falls and had several falls. LPN-A stated staff were expected to place R1's 4WW near her bed when R1 was in bed as she was impulsive and known to self transfer. LPN-A confirmed R1's 4WW was not placed next to the bed earlier that morning and was out of R1's reach. During an interview on 1/19/23, assistant director of nursing (ADON) verified R1 had several falls while self transferring. ADON confirmed one of the care planned interventions was for staff to	2 830		

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2 830	Continued From page 7 keep R1's 4WW close to her while she was in bed or in her recliner. ADON stated it was her expectation staff would have followed care planned interventions. A facility policy titled "Falls Policy" revised 5/22, revealed a fall as any unintentional change in position coming to rest on the ground, floor or onto the next lower surface. The policy identified falls were discussed with interdisciplinary team (IDT) to form potential patterns and interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls to assure proper interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		